GAP Modification Family and Child or Youth Information Worksheet

# General Directions

**Complete this form:**

* Complete this form when there has been a change in the child’s or youth’s needs, or your family’s situation has changed.
* One form for each child or youth.

**Required Information:** Provide documents showing any changes in the child’s needs or the family’s situation.

**Review Process:** We will review the child's current and future needs, the family's situation, and changes since the last GAP subsidy. DCYF has 30 days to review the application and information submitted and make a determination.

**Submission:** Submit the completed form to your HQ GAP Specialist or email: dcyf.gapspecialist@dcyf.wa.gov

# SECTION 1 – Applicant Information

## Child or Youth

Name of Child or Youth (*Last, First, Middle*)

Date of Birth  Date of this Request

## Guardians Name

Complete each section for each guardian.

**Guardian 1**

Name of Guardian (*Last, First, Middle)*

Date of Birth

Relationship with youth. Be specific. (Example: grandmother, aunt, uncle etc.)

Relationship Connection to Family: Select one [ ]  Paternal, [ ]  Maternal, or [ ]  Other explain

Street Address

City  State  Zip

Telephone Email

Guardian’s primary language if not English

Do you need an interpreter? [ ]  Yes [ ]  No

**Guardian 2** If there is only 1 guardian, check [ ]  N/A

Name of Guardian (*Last, First, Middle)*

Date of Birth

Relationship with youth. Be specific. (Example: grandmother, aunt, uncle etc.)

Relationship Connection to Family: Select one [ ]  Paternal, [ ]  Maternal, or [ ]  Other explain

Street Address

City  State  Zip

Telephone Email

Guardian’s primary language if not English

Do you need an interpreter? [ ]  Yes [ ]  No

# Section 2 – Reason for Change

Check all that apply:

[ ]  An increase or decrease in the special needs of the child or youth, or

[ ]  A change in circumstances of the guardianship family.

You must provide documentation to support this request.

1. How have the needs of the child and youth changed (increased or decreased)?
2. How have the family circumstances changed?

If you need additional space, use a separate piece of paper.

# Section 3 - Child or Youth Information

## **Education Related Information**

Age of child/youth at time of application

Grade Level of School Aged Children/Youth [ ]  Not of School Age [ ]  Birth to 3/HeadStart/Preschool

Check all that apply to the child or youth currently.

[ ]  IEP

[ ]  504 Plan/Behavioral Plan

[ ]  Birth to Three

[ ]  College

[ ]  Other please describe

[ ]  HeadStart or Preschool

[ ]  Running Start

[ ]  AP/Advanced classes

[ ]  Vocational

Describe in the types of activities selected in “other.”

Is there anything else you want us to know or think about?

## **Services from Othe Agencies (Now)**

Does the child or youth get any of these services now, or will they get them after guardianship is finalized?

* Social security services (any type). [ ]  Yes [ ]  No
* If yes, describe the type and include the amount:
* Developmental Disabilities Administration (DDA) services. [ ]  Yes [ ]  No
* If yes, describe the type and include the amount:

## **Extracurricular activities (community-based and school)**

Check all that apply child or youth currently.

What extracurricular activities are your child or youth currently participating in or the last 6 months?

[ ]  Extracurricular school activities (examples - band, cheerleading, dance teams, sports, choir, clubs, etc.)

[ ]  Extracurricular activities in community (examples - dance, church group, girl/boy scouts, YMCA, sports leagues not associated with school, etc.)

[ ]  Tutoring Outside of School

[ ]  Other, describe:

Describe in detail the types of activities selected above.

How have the needs of the child or youth changed (increased or decreased)?

# Section 4 **-** Family Circumstances

## Household

Total amount of children/youth in home  Total number of adults in home

Total number of everyone in home

## Current Family Financial Resources

Please list financial resources available to your family. Documentation may be necessary if requested.

|  |  |
| --- | --- |
| **Financial Source (current monthly income)** | **Amount** |
| Current family monthly net income (after taxes and other deductions on paycheck) **of all adults** in home | $ |
| Supplemental Security Income (SSI), Social security benefits/ Social Security (SSA) / Veterans Benefits (Guardian) of **all adults in home.**  | $ |
| Child’s Unearned Income (only) **all children or youth** in the home. Any type of social security income, or other income not earned. | $ |
| Child Support received (any children or youth in the home) | $ |
| Pensions | $ |
| Alimony/Spousal Support Received | $ |
| Unemployment Benefits | $ |
| Capital Gains/Interest/Dividends | $ |
| Savings: (Amount you have in savings today) | $ |
| Other: | $ |

Describe any changes to income:

# Recurring Family Monthly Expenses

| **Type** | **Amount** | **Type** | **Amount** |
| --- | --- | --- | --- |
| Mortgage/Rent | $ | Auto Payment(s) | $ |
| Groceries | $ | Electric/Natural Gas/Power | $ |
| Water/Sewer/Garbage | $ | Phone | $ |
| TV Service/Cable/Internet | $ | Car Insurance | $ |
| Other Insurances (Renter, RV, Life etc.) | $ | Child Support (Paid to someone – if not deducted  | $ |
| Extracurricular Activities for children and youth (Monthly average gifted programs, sports, clubs etc.) | $ | Memberships/Subscriptions: Gym, Spotify, Netflix etc.) | $ |
| Transportation/Commuting cost (Fuel, public transportation etc.) | $ | Student Loans | $ |
| Behavioral Health (not covered by insurance) | $ | Medical Expenses (not covered by insurance) | $ |
| Dependent Care (Child or elder) | $ | Other (Use next line to describe) | $ |

Other (please describe)

Describe any changes to the family’s monthly expenses.

# Section 5: Community Based Resources

* Which community resources does your family use? These can include financial help or other support services.
* If you are using a resource not listed describe under “Other”.

Select all Community Based resources your family is accessing.

[ ]  Developmental Disabilities Administration (DDA) and/or Medicaid Personal Care

[ ]  Free Lunch through schools

[ ]  Treehouse Services Describe:

[ ]  Birth to Three / Early Head Start / ECEAP / Developmental Preschool

[ ]  WIC (Supplemental Nutrition Program for Women, Infants, and Children)

[ ]  Working Connections Child Care/ Child Care (Non-needy Childcare Subsidy)

[ ]  WISe – Wraparound with Intensive Services (Funded through Medicaid).

[ ]  Housing support (example - HUD, Section 8, Community Action Funds)

[ ]  Community Programs (clothing closets, food banks, free resources)

[ ]  Other: (example - Church community, Family community)

Share anything else you want us to know or think about?

# Section 6: Determining Foster Care Maintenance Level

As of January 1, 2024, DCYF changed its method when determining the foster care maintenance level for a child or youth. Please check any that may apply for the youth in this modification request. Documentation is necessary. Provide brief description in each section you answered yes**.** See the timeframe of each diagnosis category.

Is the youth 12 and older? [ ]  Yes [ ]  No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Acute Mental Health (Last 24 months)** | **Yes** | **No** | **Acute Mental Health** | **Yes** | **No** |
| Suicide attempts or self-harm  | [ ]  | [ ]  | Polypharmacy | [ ]  | [ ]  |
| Crisis mental health services | [ ]  | [ ]  | Antipsychotic or antimanic medication | [ ]  | [ ]  |
| Inpatient MH hospitalization | [ ]  | [ ]  | Other | [ ]  | [ ]  |

Guidance: The episode has occurred within the last 24 months of the date of this request for modification.

Describe if ‘yes’ is selected for any of the above.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Chronic Physical Health (Last 3 years)** | **Yes** | **No** | **Chronic Physical Health** | **Yes** | **No** |
| Diabetes type 1 | [ ]  | [ ]  | Paraplegia | [ ]  | [ ]  |
| Diabetes type 2 | [ ]  | [ ]  | Quadriplegia | [ ]  | [ ]  |
| Severe asthma | [ ]  | [ ]  | Lymphoma | [ ]  | [ ]  |
| Dialysis | [ ]  | [ ]  | Brian tumor | [ ]  | [ ]  |
| CFS Shunt | [ ]  | [ ]  | Cancer | [ ]  | [ ]  |
| Leukemia | [ ]  | [ ]  | Organ Transplant | [ ]  | [ ]  |
| Tracheostomy/ventilator | [ ]  | [ ]  | Chronic Pulmonary Conditions | [ ]  | [ ]  |
| Muscular Dystrophy | [ ]  | [ ]  | Atrial Septal effect | [ ]  | [ ]  |
| Cystic fibrosis | [ ]  | [ ]  | Other Describe  | [ ]  | [ ]  |

Guidance: A condition is considered chronic if it has been diagnosed by a doctor, is expected to last at least one year, and will require increased use of health care resources to treat. This can be a new diagnosis or a continuation of an existing one, if the most current diagnosed is within the last three years from the date of application.

Describe if ‘yes’ is selected for any of the above.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Mental Health Prescription (Last 24 months)** | **Yes** | **No** | **Developmental Disability (Spectrum past 24 months)** | **Yes** | **No** |
| Psychotropic | [ ]  | [ ]  | Autism or other pervasive learning disability | [ ]  | [ ]  |
| Anti-anxiety | [ ]  | [ ]  | Motor or Tic (down syndrome) | [ ]  | [ ]  |
| Antidepressants | [ ]  | [ ]  | DDA Services | [ ]  | [ ]  |
| ADHD medication | [ ]  | [ ]  |  | [ ]  | [ ]  |

Guidance Mental Health Prescriptions: The child has a current psychotropic medication that is related to a mental health disorder diagnosis.

Guidance: Developmental Disability diagnosis within the past 24 months. This does not have to be a new diagnosis just a continuation of the diagnosis.

Describe if ‘yes’ is selected for any of the above.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Mental Health Diagnosis (Past 24 months)** | **Yes** | **No** | **Other Factors (Past 24 months)** | **Yes** | **No** |
| Psychotic | [ ]  | [ ]  | Determined/adjudicated SOY/Supervision Plan | [ ]  | [ ]  |
| Bi-Polar/Mania | [ ]  | [ ]  | Substance Use/disorder | [ ]  | [ ]  |
| Depression | [ ]  | [ ]  | Running away behavior | [ ]  | [ ]  |
| Anxiety | [ ]  | [ ]  | Other Describe | [ ]  | [ ]  |
| ADHD | [ ]  | [ ]  |  | [ ]  | [ ]  |
| Impulse control disorders (ODD, Conduct, Antisocial) | [ ]  | [ ]  |  | [ ]  | [ ]  |
| Trauma \* For trauma to be checked there will need to be a DSM trauma diagnosis. | [ ]  | [ ]  |  | [ ]  | [ ]  |

Guidance: A mental health diagnosis within the past 24 months. This does not have to be a new diagnosis just a continuation of the diagnosis.

Describe if ‘yes’ is selected for any of the above.

# Section 7: Signature(S) of Applicants

I agree that the details provided here are and the documents are both true and correct to the best of my knowledge. Not being truthful may result in my form being rejected or my GAP payment being suspended.

Guardian Signature  Date

Guardian Signature  Date